DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 12/25/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	11/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to provide privacy when administering medications for one resident (#4) of twenty residents reviewed. The findings included:	F 164	F164 The identified employee was individually in-serviced By the DON. The DON did a medication pass audit on the employee Audit is on employee record. Re-education Progressive discipline will be accomplished if employee demonstrates continued non-compliance. All licensed staff, including PRN and staff on leave, will be in-serviced on medication Administration by the DON or ADON To identify others who are potentially affected, the facility administrator will conduct a facility in-service on patient privacy and dignity. This will be accomplished for all staff, prn and part time by 12-05-2010. Any employee who is on vacation or leave will have in-servicing prior to entering the next scheduled shift. Medication pass will be audited once a week on each shift by the DON, or ADON in her absence, then monthly thereafter. (Audit form attached) A report of audit results shall be given to the QA Committee, which meets quarterly and consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor. The administrator will make twice weekly walking Rounds on random shifts for one month to observe For compliance. Any identified deficient practice will be addressed by re-education and progressive discipline. This will be the responsibility of the administrator and Appropriate department supervisor. A record of training and discipline will be kept in the Employee file.	11-10-2010 11-23-2010 11-23-2010 12-17-2010 12-05-2010 11-18-2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda K Williams — TITLE: Administrator — (X6) DATE: 11-27-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 Observation of the medication pass on November 9, 2010, at 8:10 a.m., revealed the Licensed Practical Nurse (LPN) #2 administering medications to resident #4 who had a gastrostomy tube in place. Continued observation revealed LPN #2 pulled back the covers and accessed the gastrostomy tube but failed to draw the privacy curtain. Further observation revealed the resident's room-mate was seated in a chair facing the bed of resident #4. Continued observation and interview revealed the room-mate was alert and oriented. Review of the facility policy Medication Pass Techniques revealed "ensure anytime resident is to be exposed, that curtain is pulled." Interview with LPN #2 on November 9, 2010, at 8:30 a.m., in the resident's room confirmed LPN #2 failed to pull the privacy curtain prior to administering the mediations via the gastrostomy tube.	F 164		
F 279 SS=F	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

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F 279	Continued From page 2 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plans to reflect aspiration precautions for five residents (#5, #14, #12, #19, #20) of eight residents reviewed for residents at risk for aspiration. The findings included: Resident #5 was re-admitted to the facility on May 4, 2010, with diagnoses including, Recurrent Pneumonia, Diabetes Mellitus, and Alzheimer's Dementia. Medical record review of the Minimum Data Set (MDS) dated August 31, 2010, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living. Medical record review of a Speech Therapy discharge note dated September 14, 2010, revealed "...Discharge Recommendations...cont. (continue) asp (aspiration) precautions...thin (liquids) via cup..." Observation in the resident's room on November 8, 2010, at 10:35 a.m., revealed a sign on the wall	F 279	The staff was in-serviced immediately beginning on November 9 through November 13 regarding the affected residents and on the facility policy for aspiration precautions, including the use of straws An audit was done to remove straws from the affected Residents.	11-13-2010
			Care Plans were checked and updated by the Care Plan Coordinators for all affected residents	11-09-2010
			To identify others who could be at risk, a list of patients with speech therapy recommendations for swallowing /aspiration precautions was updated by the Patient Care Coordinator for all residents on aspiration precautions and who are not to use straws. This list was placed on the MAR, the CNA observation books and in a notebook in the dining room and activity room. The DON checked all residents on the list to make sure that Precautions were posted in rooms with a cover sheet.	11-09-2010
			The list will be updated by the Dietary manager weekly, Based on new diet orders. A copy will be given to the patient care coordinators to assure that the care plan is updated for speech therapy recommendations and orders. The speech therapist will re-screen at risk residents Quarterly and revisions will be addressed with diet orders.	11-10-2010
			A sign will be posted on each wing informing Visitors to check with the charge nurse before offering food or drink to any resident.	12-05-10

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F 279	Continued From page 3 next to the resident's bed stating "Swallowing Precautions for (resident) Diet: ...thin liquids ****NO STRAWS..." Observation revealed the resident requested a drink and the Assistant Director of Nursing (ADON) gave the resident a drink from the ice water pitcher using a straw (no choking noted). Continued observation revealed liquid supplement in a cup with a straw on the resident's over the bed table within the resident's reach. Further observation revealed the ADON offered the resident a drink of the supplement but the resident refused. Medical record review of the resident's care plan dated October 2, 2010, revealed no interventions for the resident to not use straws for drinking as part of the swallowing precautions. Interview with the ADON in the resident's room on November 8, 2010, at 10:38 a.m., confirmed the sign on the wall stated "No Straws" and the ADON gave the resident a drink of ice water using a straw. Interview on November 9, 2010, at 9:40 a.m., at the A B nursing station with the Speech Therapist revealed Swallowing Precautions were posted on the wall, with NO STRAWS in red letters. Continued interview and review of the resident's current care plan confirmed the precaution "No Straws" was not addressed on the resident's current care plan. Interview via telephone on November 10, 2010, at 8:00 a.m., with Licensed Practical Nurse (LPN) # 4 revealed LPN# 4 administered the resident's 8:00 a.m., medications on November 8, 2010, and also gave the resident the liquid supplement, "...the resident was having trouble swallowing so I	F 279	To assure compliance, the AT RISK COMMITTEE, Consisting of the Dietary Manager or Designee, Director of Nursing or ADON, Care Plan Coordinator, Social Worker, Activity Director and Restorative Supervisor, will review and discuss residents with aspiration precautions. Any identified non-compliance will be addressed through patient and family education, food consistency waivers, or progressive employee discipline. The AT RISK committee will submit a report to the QA Committee quarterly. The QA Committee , which meets quarterly consists of the Administrator, Director of Nursing, Medical Director, Pharmacist ,Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor.	

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F 279	Continued From page 4 got a straw and (resident) drank ½ of the supplement..." Resident #14 was re-admitted to the facility on October 20, 2010, with diagnoses of Pneumonia, Congestive Heart Failure, and Anemia. Medical record review of the resident's MDS dated August 23, 2010, revealed the resident required assistance with all activities of daily living. Medical record review of the current care plan dated October 13, 2010, revealed no interventions for the resident to not use straws for drinking as part of the swallowing precautions. Observation on November 9, 2010, at 3:30 p.m., in resident #14's room revealed no sign near the resident's bed to alert staff and family to not use straws as part of the resident's swallowing precautions. Interview on November 10, 2010, at 9:00 a.m., at the A B nursing station with the Speech Therapist revealed resident #14 is not to use straws for drinking as part of the resident's swallowing precautions. Interview on November 10, 2010, at 10:25, in the MDS office with the clinical care coordinator, confirmed approaches for the swallowing precaution "No Straws" was not addressed on the resident's current care plan. Resident #12 was admitted to the facility on March 19, 2010, and readmitted on October 13, 2010, with diagnoses including Hypertension, Chronic Obstructive Pulmonary Disease,	F 279		

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F 279	Continued From page 5 Osteoarthritis, and Left Above Knee Amputation. Medical record review of a physician's order dated May 18, 2010, revealed an order from Speech Therapy for "Change diet to regular (cardiac) diet with no hard/crunchy or dry/crumbly foods and thin liquids - no straw." Medical record review of the physician's recapitulation orders dated October 2010, revealed an order originally written on June 16, 2010, which stated "Regular cardiac diet with thin liquids; no straw; no hard crunchy or dry crumbly foods." Medical record review of a Speech Therapy notes dated June 21, 2010, revealed "Cardiac diet. No straws, hard/crunchy or dry crumbly foods." Medical record review of the Care Plan dated October 9, 2010, revealed no interventions for the resident to not use straws. Observation of the resident's room on November 9, 2010, at 3:20 p.m., revealed no signs posted the resident was not to use straws. Resident #19 was admitted to the facility on August 17, 2009, with diagnoses including Dementia, Macular Degeneration, Hypertension, and Paroxysmal Atrial Fibrillation. Medical record review of a Dietary Progress Note dated July 15, 2010, revealed "Remove straws from meal tray per ST (Speech Therapy)." Further medical record review of the dietary notes revealed the resident received a mechanical soft diet with ground meats with aspiration precautions.	F 279		

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F 279	Continued From page 6 Medical record review of the current Care Plan revealed no intervention for the resident to not use straws. Observation of the resident's room on November 9, 2010, at 3:45 p.m., revealed no signs stating the resident was on aspiration precautions, what aspirations precautions consisted of, and the resident was not to use a straw. Resident #20 was admitted to the facility on November 16, 2009, with diagnoses including Gastroesophageal Reflux Disease, Dementia, and Hypertension. Medical record review of the dietary notes revealed the resident receiving a mechanical soft ground diet with nectar thick liquids. Medical record review of Speech Therapy notes revealed "Diet: Mech. (mechanical) soft, nectar liquids, natural nectar and carbonated beverages, 0 (no) straw." Medical record review of the current care plan revealed no intervention for the resident to not use straws. Observation of the resident's room on November 9, 2010, at 4:10 p.m., revealed no signs in the room to indicate the resident was to have nectar thick liquids and no straws. Interview, with the Director of Nursing (DON) and Clinical Care Coordinator on November 10, 2010, at 10:00 a.m., in the DON's office, confirmed residents #12, #19 and #20 were not to have straws. Further interview confirmed care plans	F 279		

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F 279	Continued From page 7 were not revised to not use straws for residents #12, #19 and #20.	F 279		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure safety measures for residents with a gastrostomy tube for one resident (#4) of twenty residents reviewed. The findings included: Observation during the medication pass on November 9, 2010, at 8:10 a.m., revealed Licensed Practical Nurse (LPN) #2 injected ten ml (milliliters) of water into the gastrostomy tube of resident #4 and aspirated ten milliliters of stomach contents. Continued observation revealed LPN #2 failed to auscultate the abdomen to determine correct placement of the tube. Review of the facility policy Medication Pass Techniques revealed "...a. check for placement and residual...b. flush with at least 60 ml water...c. administer medications by gravity...d. flush with	F 322	The identified employee was individually in-serviced By the DON. The DON did a medication pass audit on the employee. Audit is on employee record. Progressive discipline will be accomplished if employee Demonstrates non-compliance. All licensed staff, including PRN and staff on leave, will be in-serviced on medication Administration by the DON or ADON Medication pass will be audited once a week for one month on each shift by the DON Or ADON in her absence, then monthly thereafter. (Audit form attached) A report of audit results shall be given to the QA Committee, which meets quarterly and consists of The Administrator, Director of Nursing, Medical Director, Pharmacist, Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor for follow-up recommendations.	11-10-2010 11-23-2010 11-23-2010 12-17-2010 11-23-2010

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F 322	Continued From page 8 60 ml water." Interview with LPN #2 on November 9, 2010, at 8:25 a.m., in the resident's room, confirmed LPN #2 failed to check placement of the gastrostomy tube.	F 322		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	The facility has no residents who use NG tubes. The old product was removed immediately. The open supplies were discarded from stock. 11-09-2010 The Central Supply clerk checked both medication rooms Thoroughly. 11-09-2010. The expired Vitamin C bottle was no longer being used as Vitamin C is now dispensed through a Med PAC. It was removed from stock. 11-09-2010 The Central supply clerk has been in-serviced on moving oldest stock to the front or top of supply as new stock is relaced. She will check for outdated stock weekly and restock as indicated. (inservice record attached) 11-09-2010 The DON will be responsible for assigning and overseeing a charge nurse and the Central Supply person to check the medication rooms and carts for outdated medical supplies, preparations and medications weekly. The treatment nurse will check the treatment cart weekly to assure that any outdated or opened supply is removed 11-25-10 The consulting pharmacist will also check medical supplies in the future when checking the medication room for oversight of compliance Identified staff non-compliance will be addressed through re-education and progressive discipline from the Director of Nursing, or ADON, in her absence. A report of audit results shall be given to the QA Committee, which meets quarterly and consists of The Administrator, Director of Nursing, Medical Director, Pharmacist,Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor, for review and recommendation. 11-24-20	

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F 431	Continued From page 9 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of the medication rooms the facility failed to ensure drugs and biologicals were not expired in two of two medication rooms. The findings included: Observation of the medication room on the A/B wing on November 9, 2010, at 10:00 a.m., revealed one PICC (peripherally inserted central catheter) dressing kit had the outer covering opened revealing the wrapped contents which are sterile and would become contaminated if open to air sitting on the shelf and available for resident use. Continued observation of the medication room revealed one secondary intravenous set open on the shelf and available for resident use. Further observation of the medication room revealed five packages of Ross enteral feeding tubes, #16 French 36 inches, with "Use by January 2009", and one package with "Use by August 2010" printed in large black letters on the packages. Interview, with LPN (Licensed Practical Nurse) #1 on November 9, 2010, at 10:30 a.m., in the medication room, confirmed the PICC line and secondary IV kits were open on the shelf, and the six packages of enteral feeding tubes were outdated and all were available for resident use.	F 431		

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F 431	Continued From page 10 Observation of the Medication room on C wing on November 9, 2010, at 10:35 a.m., revealed one bottle of Vitamin C 500 mg (milligram) tablets, 1000 tablet bottle, which had been opened and some tablets removed, with an expiration date of October 2010 on the shelf and available for resident use. Interview with LPN #1 on November 9, 2010, at 10:50 a.m., in the medication room, confirmed the bottle of Vitamin C tablets was expired and still on the shelf available for resident use.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and interview, the facility failed to document administration of pain medication accurately and completely for one resident (#9) of twenty residents reviewed. The findings included:	F 514	The DON did individual in-service with the nurses who were involved. 11-10-2010 To identify other residents at risk, the DON implemented an audit formto be used daily by the A/C lead nurse and the B Wing charge nurse. 11-28-2010 All licensed staff will be in-serviced by the DON and ADON 12-17-2010 The 7-3 B wing charge nurse and the A/C lead nurse will do daily audits for PRN medications for 4 weeks, then weekly thereafter. 11-28-2010 The DON will oversee the audit process. Any identified non-compliance will be addressed by the DON or ADON through re-education and progressive discipline. A report of audits will be given to the QA committee , which meets quarterly and consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor, for review and recommendations.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 11 Resident #9 was admitted to the facility on July 21, 2007, and readmitted on October 13, 2010, with diagnoses including Hypertension, Congestive Heart Failure, Chronic Renal Insufficiency, Benign Prostatic Hypertrophy, Osteoporosis, Peripheral Vascular Disease, Gastroesophageal Reflux Disease, Diabetes Mellitus, Coronary Artery Disease, Cerebrovascular Accident with Right Hemiparesis, Abdominal Aortic Aneurysm, and Coronary Artery Bypass Graft. Medical record review of the physician's orders dated October 13, 2010, revealed an order for "Hydro-APAP 5/325 mg (milligrams), give 1-2 tabs by mouth every 4 hours as needed for pain". Medical record review of the Medication Administration Record (MAR) for October 17, 2010, revealed a pain assessment of "3" on the 11:00 p.m. to 7:00 a.m., shift and a pain assessment of "4" on the 7:00 a.m. to 3:00 p.m., shift but no documentation of pain medication administered (Pain assessment is done on a scale of 1 - 10 with 10 being the worst pain.). Continued medical record review of the MAR for October 18, 2010, revealed a pain assessment of "4" on the 3:00 p.m. to 11:00 p.m., shift but no documentation of pain medication administered. Further medical record review of the MAR for October 22, 24, and 25, 2010, revealed a pain assessment of "5" on the 3:00 p.m. to 11:00 p.m., shift on each day but no documentation of pain medication administered. Further medical record review of the MAR for October 29, 2010, revealed a pain assessment of "4" on the 3:00 p.m. to 11:00 p.m., shift but no documentation of pain medication administered. Continued medical	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	11/10/2010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 12 record review of the MAR for October 31, 2010, revealed a pain assessment of "4" on the 7:00 a.m. to 3:00 p.m., shift but no documentation of pain medication administered. Further medical record review of the MAR for November 4, 2010, revealed a pain assessment of "4" on the 3:00 p.m. to 11:00 p.m., shift but no documentation of pain medication administered. Review of the facility policy PRN Medications revealed "When giving PRN (as needed) medications, they must be documented on the back of the MAR. The date and time the medication was given, the medication and dosage, the reason for the medication, the results/response to the medication, and the initials of the nurse administering the medication." Interview with the DON revealed the pain medications were signed out on the Narcotic Tracking/Destruction Log. Further interview with the DON revealed these logs are not a permanent part of the resident's record but are kept in a file in the DON's office. Interview with the Director of Nursing (DON) on November 10, 2010, at 9:30 a.m. in the DON's office, confirmed the doses of pain medication were given and documented on the Narcotic Destruction Records but were not documented on the MAR.	F 514		